DEZINSTITUTIONALIZATION OF THE SOCIAL SERVICES FOR THE ELDERLY PEOPLE IN THE CZECH REPUBLIC

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Abstract:

In this paper is described the social service system for the elderly people in the Czech Republic as well as the process of transformation in this field over the last years. The part of these changes, what will be presented, is the concept of deinstitutionalization the residential care. This concept was worked up in connection to main pillars of the transformation the care: implementation of the quality standards into social service providing and the setting of the social service on the local level (through the community planning method). In the another part of this text will be discussed the results of the research on community care service in the Czech Republic, the difficulties in providing this kind of support and actual potential of this service to cover the needs of the elderly people in the locality.

Key words: elderly, social services, residential care, community care service

The following text is structured to the three parts. In the first part is briefly described the Czech social security system as well as the process of the personal social service systems transformation. The second part of this text is focused on the system of social service, particularly for the elderly. The demographic trend of the Czech population will be shortly presented in this part also. In the last part is presented the role of the community care service. In connection with the progress of deinstitutionalization of residential care are discussed main results of the research on case study of agency providing community care service.

The personal social services as a part of Czech social policy

Social security system in Czech Republic is the part of the government social policy. It is a set of institutions and measures
designed to prevent, alleviate or eliminate the consequences of social events affecting citizens. The conception of social security is usually described as a model of “three pillars”. The first one is the Social insurance pillar – citizens or groups of citizens reduce their present consumption for the sake of uncertain future social events (health insurance, unemployment insurance, retirement pension insurance, etc.). The second is the State social support pillar – citizens are protected against specific social events defined by the state; state social support represents in fact a solidarity scheme organised by the state and based on the principle of redistribution of resources. The third is the Social assistance pillar – unlike insurance and support, social assistance is applied individually; it involves protection of citizens against such situations that can neither be managed by means of insurance and nor is there entitlement to state social support. In cases of material need the assistance can be both financial and material, however there is no fixed entitlement to it and claims cannot be automatically set up; in case of social need the situation is usually managed by temporary or permanent provision of personal social services (Musil, Kubalčíková, Nečasová, 2008, p. 96).

As regards the first two pillars the reform has in fact been completed in the early nineties (social insurance) and mid-nineties (state social support) with basic principles governing the implementation of the pillars embedded in a relevant set of legal regulations. The social assistance and, even more importantly, personal social services “official” reform was initiated not long ago, but since 1989 this part of social policy have gone through a dynamic way in the field with a lot of profound changes.

Since 1999 to 2002 the Ministry of Labour and Social Affairs took an important step towards the completion of the “official” social service reform and establishment of its legislative framework. The key reform activities were defined as follows: organization and planning the social services on the local level (on the principle of community planning); implementation of quality standards and monitoring the quality of service providing; reform of the social services financing.

The method of community planning is based on the involving of users, representatives of providers and representatives of local authorities into the process of planning the personal social services setting on the local level. The most important principle of
this method is the assessment of the users needs (Metodiky plánování sociálních služeb, 2007).

The Standards of quality are defined as a set of measurable and verifiable criteria for determining whether the basic principles of personal social service are satisfied. Through the Standards is described what a quality service should look like. There are 17 standards divided into three types: procedural standards of quality, standards of quality related to human resources, operational standards of quality. They apply uniformly to all social services, i.e. regardless of the type and scope of service (Standardy kvality, 2002).

Through the reform of financing was changed the principal differences between the services providers - the regional authorities and municipalities on the one hand and the non-governmental bodies on the other one – in the access to subsidies from public resources. The considerable part of the money is coming now to all providers via the special contribution for the users which is determined by the level of dependency of each user.

These basic principles what were just mentioned are included into new Law on social service. This comprehensive legislation has been ratified in 2006, from January 1\textsuperscript{st} 2007 this new law came into force. The personal social service is there defined as activities offered to people who find themselves in unfavourable social situations and is aimed at encouraging social inclusion and protecting against social exclusion.

**The system of personal social services for the elderly**

The social service typology is contains in one part of new legislation also, it is based on the nature of the unfavourable social event. There are defined three sets of social services: social counselling (general and special social counselling), social care services (including services like personal assistance, respite care, emergency service, residential care, stationeries, community social care, etc.) and social prevention service (including services like asylum housing, hostels, contact points, crisis intervention, therapeutic communities, family centred social-activity services or elderly centred social-activity services, etc.).

It is possible to say that the elderly people are the most often users of social services in the Czech Republic and the demographic trend is there very similar to other European countries. In 2006 has been the proportion of 65+ age group 14,4\% in gross population, the
proportion of 0-14 age group 14.4% and the rate of 15-64 age group 71.2% in gross population. Index of ageing (i.e. 65+/0-14) was 100.2 that year. The absolute number of the elderly citizens as well as their proportion in gross population will grow up in next decades. This trend is presented in Table 1 in detail.

Tab. 1 Demographic forecast of Czech population

<table>
<thead>
<tr>
<th>Year</th>
<th>Age category (both sexes)</th>
<th>Population Total (both sexes)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>60+</td>
<td>65+</td>
</tr>
<tr>
<td>abs.</td>
<td>%</td>
<td>abs.</td>
</tr>
<tr>
<td>2002</td>
<td>1 932 198</td>
<td>18.9</td>
</tr>
<tr>
<td>2010</td>
<td>2 337 013</td>
<td>22.7</td>
</tr>
<tr>
<td>2020</td>
<td>2 719 639</td>
<td>26.4</td>
</tr>
<tr>
<td>2030</td>
<td>2 973 672</td>
<td>29.4</td>
</tr>
<tr>
<td>2040</td>
<td>3 481 408</td>
<td>35.5</td>
</tr>
<tr>
<td>2050</td>
<td>3 650 619</td>
<td>38.7</td>
</tr>
</tbody>
</table>

Source: Projekce obyvatelstva, 2004
The sector of social services for the elderly in Czech Republic is based on the general services system as was described above. Service for the elderly can be divided into two main groups: institutional (residential) care and non-institutional forms of care. The residential care is provided in two types of residential houses: the elderly houses and the houses with the special statute.

Elderly houses are intended for users with permanent health impairments who are not able to live and independent life. There is the complex care provided – accommodation, board, hygiene, health care, cleaning service. In addition, some homes also have a nursing department for users permanently confined to bed. Some of the houses are only focused at users with permanent depth health problems or for example with psychiatric diagnose or mostly for dementia, these are houses with the special statute (usually is there more health care professionals like a nurses).

Non-institutional care can be provided in several kinds of establishments: The day-care centres or special centres for people with dementia – they commonly include driving the users in and offer meals and hygiene as an optional extra; The temporary residence (respite care) – the users can stay for the maximum of 3 months, the facility can be used e.g. for elderly people who are waiting for placement in an elderly house and can no longer stay in their own household, it can also be used as respite for users’ families – it provides the families with a temporary relief from the provision care; The elderly peoples’ clubs where are organized usually social-activity programs.

The most frequently form of this non-institutional care is definitely the community social care. This service in normally available in each town and is serves to those senior citizens who cannot provide for their own needs on the grounds of ill health, nor can they receive permanent help from their family. The set of activities that community social care can offer are defined by legislation, as well as this form of service includes meals-on-wheals. On the other hand the community social care does not include health care, but the users with permanent health problems can use the health home-care simultaneously. Community social care is provided in clients’ household as filed work service as well as can be delivered to elderly people who living in the houses with special flats similar to shelter housing (or subsidised housing). Elderly people live there in apartments, where they move from their own household, bringing their furnishings along, the relatives or friends
can visit them, inhabitants can have dog or cat or other pets here. These residents are provided with the same services as the users who live on their own.

What can be mentioned as the negative features of the elderly services system in general? The founding of new elderly houses is often rationalized by the number of applicants; however applications for placement in elderly houses are hardly ever dealt with in a systematic manner – reasons for applicants’ interest in the homes are not explored, many people submit their application years in advance. Individual forms of services are hardly ever mutually linked within a coherent system. Co-operation between institutional care and non-institutional services is particularly poor – institutional care is often guaranteed by regional authorities or in bigger town by municipality and is provided in the form of big home, while non-institutional care is typically organized at a local level and often provided by non-governmental non-profit agencies. Elderly houses or houses with the special statute provide standardized care – each user is provided with the same set of service (except for the health care), regardless of their individual abilities and degree of dependency, usually all of them have meals 5 times a day, cleaning, washing etc. The care is targeted before anything else at material needs. The activation of users and fulfilment of non-material needs as well as the co-operation with the users’ family or contact with the community, is usually still a private initiative of director or employees. The standard of accommodation varies widely: while new buildings meet modern norms, many homes function in buildings that are 80 years old or older (former small castles) and their historical value make modernization difficult. The care is mostly institutionalized and “medicalized”. The basic data about social services for the elderly in Czech Republic are presented in Table 2.

**Tab. 2 Social care establishment for elderly in Czech Republic**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>2000</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elderly houses</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Establishment</td>
<td>491</td>
<td>508</td>
<td>522</td>
<td>535</td>
<td>543</td>
</tr>
<tr>
<td>Capacity</td>
<td>48 791</td>
<td>50 068</td>
<td>50 818</td>
<td>50 740</td>
<td>50 889</td>
</tr>
<tr>
<td>Occupancy rate (%)</td>
<td>94,4</td>
<td>94,9</td>
<td>94,3</td>
<td>96,3</td>
<td>96,8</td>
</tr>
<tr>
<td>Persons provided</td>
<td>113 528</td>
<td>141 813</td>
<td>113 136</td>
<td>109 47</td>
<td>112</td>
</tr>
</tbody>
</table>

community care service (in total) |  |  | 5 | 927
---|---|---|---|---
Houses providing community care service | 927 | 915 | 911 | 958 | 977
Houses Dwelling units | 25 985 | 27 948 | 27 169 | 29 039 | 30 888

*Source: Czech Statistical Office*

**Transformation of the institutional care and the role of the community care service**

In February 2006 was accepted the government decree The conception of transformation residential care to other forms of social services which could be provided in the natural environment of the users and could encouraging their social inclusion to the community (Usneseni, 2007). For this process is in the document used the term “deinstitutionalization”. As concern the sector of social service for the elderly is expressed in this government decree to give more support to field work services (i.e. community care service) as well as non-resident (ambulant) form of social services as the day-care centres and respite care.

The recent demographic trends in the ČR make it clear that the provision of services for the elderly will grow ever more demanding. Community care service has a great potential to support the elderly people in their natural environment. Unfortunately, this potential has not as yet been utilized to the full and the service provision doesn’t often correspond with today’s needs of the elderly. In the text follow will be briefly outline the most important findings of the Community care service provider research.

The research has been conducted by the Research Institute for the Labour and Social Affairs (RILSA) in co-operation with Department of Social Policy and Social work at the Faculty of Social Studies Masaryk University in Brno in 2001-2004. Upon negotiations with the Ministry of Labour and Social Affairs of Czech was included the community care service agency founded by the municipality (town with the 30 thousand inhabitants) in the research. The research proceeds from the assumption that every organization, including the agencies providing social services, has developed a specific organisational culture and workers have
developed certain routine stereotypes in the provision of social care. Considering the research intention was very necessary to comprehend the very nature of the organisations’ functioning.

As the research method has been decided on a case study method carried out by means of semi-standardised and in-depth interviews. The research was organized in three stages – the first stage consisted in interviewing the staff, the second stage in interviewing the users and at the third stage interviews were carried out with the founders – representatives of the local authorities). Now will be shortly described selected results of this research.

The general expectation is that the community care service could cover different types of needs. The standard practice is to focus on the material aspects of service, i.e. satisfying material needs such as meal-on-wheal, shopping, cleaning, etc. Non-material care is considered above the usual standard. The Standards of quality require the formulation and pursuit of the users’ personal goals that correspond with their individual possibilities and abilities. The users whose problems are non-material in nature (such as social isolation) are put in a position where they can only formulate their demands within the limits of material care. On the other hand the assistants express the qualms concerning the prestige of their job when arguing they aren’t just the “cleaners”. This stress on prestige can be at the background of sensitivity towards situations in that they are confronted with expectations of some users. When workers whose official job is to provide solely material care service don’t respond to these “troublesome” expectations, they can really perceive themselves as “just a cleaner”.

The education of the staff could correspond with users’ specific needs. The practice is to consider the current qualification of community care service assistant sufficient – that is only the 3 months basic health care course. Further educations is seen as of no use. This view that current qualification is sufficient follows from the prevailing material approach to care. However, such approach is further reinforced precisely by the inadequate qualification of the community care service assistants.

The practice is to disregard the complex situation when assessing applicants’ needs. The prevailing concern is whether meeting more complicated needs of a user would not interfere with the routine provision of the service. Nevertheless the requirement of the new legislation is to set such goals of intervention that reflect the possibilities, abilities and specific problems of individuals. The
workers are not used to setting goals on the basis of analysing the applicant’s situation and they don’t seek to determine such needs which cannot be met by routine procedures. They prefer to continue their habitual style of work. A part of clients’ needs thus remains undefined.

The practice is to react to aggravation of a client’s condition with a delay. The precondition of the social service providing by the new legislation is that will be elaborated individual plan of care and regular monitoring of the users’ condition and evaluation of individual plans. The assistants are unaware that such practice puts users at risk. The skill needed in designed individual plans of care and monitoring users’ condition require certain level of qualification. Poorly qualified workers are in doubt when it comes to meeting this requirement in practice.

**Conclusion**

The population of elderly people in Czech Republic grow up and it will be the future demographic trend also. Elderly houses as the part of social service system for this target group are on the one hand relatively expensive form of service and on the other hand is possible describe several problems with providing, typical for the residential care. By the government was accepted intention of deinstitutionalization the sector of social services for the elderly people. In connection with some outcomes of the research realized as the case study of community care service providers could be said that must be done the convenient conditions for the transformation of big elderly houses. Before anything else the conditions for the development of community care service, firstly to human resources. Is necessary support the education of the assistants who are the front line workers and are in everyday contact with the users. Secondly is also important that will be there sufficient staff number. What seems as the key point is to incorporate the position of social worker in the staff structure. Social worker (strictly speaking social workers) with certain level of qualification for the assessment of users life situation and needs, as well as relevant skills for elaboration the individual care plan and monitoring users’ abilities and specific problems. If the community care service should be the ground or main pillar of the social service system for the elderly people the offer will have to professionally cover whole spectrum of peoples’ needs, i.e. material as well as non-material.
Bibliography
